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March 24, 2006

VIA HAND DELIVERY
Board of Directors
Attn: Lynn Theberge
Dirigo Health Agency
53 State House Station
Augusta, Maine 04333-0053

In Re: Determination of Aggregate Measurable Cost Savings
FOR THE SECOND ASSESSMENT YEAR (2007)
FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

SUBMITTED BY: Christopher T. Roach

DATE: March 24, 2006

DOCUMENT TITLE: Anthem BCBS Pre-Hearing Brief

DOCUMENT TYPE: Brief

CONFIDENTIAL: **NO**

Thank you for your assistance in this matter.

Very truly yours,

Christopher T. Roach
cc: William Laubenstein, Esquire
William Stiles, Esquire
Bruce Gerrity, Esquire
D. Michael Frink, Esquire
Joseph P. Ditre, Esquire
Kelly Turner, Esquire
James Smith, Esquire

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PRE-HEARING BRIEF
THE SECOND ASSESSMENT YEAR	)	
(2007)	)	
	)	

Intervenor Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS"), by and through its attorneys, files this Pre-Hearing Brief in support of its position in this matter pursuant to Procedural Order No. 3 issued by the Board of Directors of the Dirigo Health Agency (the "Board") on February 22, 2006. As reflected below, Anthem BCBS has been denied a meaningful opportunity to participate in this proceeding and the methodologies proposed by the Dirigo Health Agency ("DHA" or "Agency") are flawed and will overstate the cost savings that are actually attributable to the operation of Dirigo Health. Anthem BCBS requests that the Board go forward with the hearing as set forth in its Response to the Recommended Decision and adopt the alternative methodology proposed herein and in the prefiled testimonies of Jack Keane and Sharon Roberts.

INTRODUCTION

Anthem BCBS was granted intervenor status by order of the Board dated February 17, 2006. Anthem BCBS is the largest health insurer in the State of Maine and, in addition, provides administrative services for a number of self-insured employers in Maine, and serves as carrier for DirigoChoice.

Anthem BCBS fully supports the goals of the Dirigo Health Agency (the "Agency") and the objectives of the Dirigo Health Act (the "Act"). However, in the interests of its group and individual members, Anthem BCBS is committed to ensuring that the amount of the savings offset payment ("SOP") reflects no more than the aggregate measurable cost savings ("AMCS") resulting from the operation of Dirigo Health. Requiring insurance carriers such as Anthem BCBS, and, in turn, those with private insurance, to pay an SOP that is inflated beyond the actual cost savings as a result of the operation of Dirigo Health is an unfair financial burden on those with insurance and will result in more Mainers becoming uninsured. That result would be directly contrary to the fundamental goals of the Dirigo Health Act. The purpose of Anthem BCBS' participation in this proceeding is to ensure that the AMCS calculated by the Board is reasonably accurate and in compliance with the Act.

DISCUSSION

I. THE PROCEDURAL ORDERS, AND DHA'S FAILURE TO COMPLY WITH ORDERED DEADLINES, HAVE DENIED ANTHEM BCBS A MEANINGFUL OPPORTUNITY TO PARTICIPATE

When the DHA Board distributed a draft procedural order for this proceeding that (1) required the intervenors to designate witnesses, summarize testimony and exchange documents before the Agency was required to divulge its methodology and calculation for the aggregate measurable savings for the second assessment year, and (2) omitted the opportunity for discovery, the intervenors objected both to the procedural structure for the case and that their ability to participate meaningfully in this proceeding was dependent on the Agency providing information and data relevant to the calculation of AMCS. The Board rejected the intervenors' objections and requests for discovery, ordering instead the intervenors could seek the information they needed via Freedom of Access Act Requests.

The result of this order has been as follows:

- DHA failed to produce its designation of witnesses, summaries of witness testimony or to exchange or designate any documents on March 10, 2006, the deadline established in the Procedural Order;

- DHA failed to designate its methodology or provide any of the data supporting its methodology on March 13, 2006, the deadline established by the Procedural Order.

- Despite prompt service of FOAA requests from both Anthem BCBS and the Maine Association of Health Plans on February 24 and 28, respectively, DHA did not produce any documents until March 17, when the Agency was ordered to do so by the Hearing Officer;

- By virtue of DHA's delays, the Hearing Officer postponed the testimony submission date from March 20 to March 22;

- Notwithstanding the Hearing Officer's order, DHA did not produce on March 17 any responsive documents in the possession of the consultants who have been developing the AMCS methodologies for the second assessment year;[1]

- After Anthem BCBS was thereafter forced to file a Motion for Clarification of the Hearing Officer's order to compel production of responsive documents from DHA's consultants, on March 22, the date that all prefiled testimony was due, DHA's counsel committed that, upon receipt of an administrative subpoena, Mercer would produce all documents responsive to the FOAA requests that are not proprietary to Mercer (*i.e.*, trade secrets);

- Anthem BCBS that same day drafted the administrative subpoena and emailed it to all counsel, including counsel for Mercer. Given the hearing is set to commence on Tuesday March 28, the subpoena required production of responsive documents by Friday, March 24 at 12:00; and

- Notwithstanding the lengths Anthem BCBS has gone to obtain the documents that are necessary for its preparation for the hearing, as of the time of this filing, the Agency has produced none of the underlying data and information that its consultants have used, relied upon or considered for the second year assessment methodologies.

The Agency has taken all of these actions without consequence from the Agency's Board.

[1] The Agency's position is flatly contradicted by Maine court decisions on this point. *See Bangor Pub. Co. v. Univ. of Maine Sys.*, No. CV-95-223 (Me. Super. Ct., Pen. Cty. Dec. 4, 1995) (requiring production of documents in custody of governmental entity's private law firm); *Guy Gannett Communications v. MSAD No. 6*, No. CV-97-084 (Me. Super. Ct., York Cty., Apr. 30, 1997) (requiring production of documents in custody of governmental entity's private insurer). See also Anthem BCBS's Motion for Clarification filed on March 20, 2006 and joined in by two other parties.

In spite of the Agency's repeated failure to meet the deadlines established by its own Board in this proceeding, the intervenors have met every deadline: witness designations, summaries of testimony, expert designations and designation of documents were all filed on March 10 and Anthem BCBS, along with others, filed its identification of alternative methodology on March 13, notwithstanding that DHA had not as yet even identified its proposed methodology.

Anthem BCBS also submitted prefiled testimony on March 22, as required by the Hearing Officer, however, Anthem BCBS's witnesses were forced to make significant assumptions as a result of the Agency's failure to identify its methodology until March 20th, coupled with the lack of discovery and the failure to provide any documentation and data to back up the Agency's proposed methodology. Anthem BCBS's witnesses cannot provide adequate and complete testimony because they have not been fully informed as to the Agency's methodology and calculations about which they are supposed to testify.

While certainly more could be said, in short, the procedures developed by the Board for this process, and its failure to provide consequences for its Agency's failure to comply with multiple ordered deadlines, have not produced the full and fair adjudicatory proceeding required by the Maine Administrative Procedures Act. 5 M.R.S.A. §§ 9054 *et seq.* Anthem BCBS has been, and continues to be, substantially prejudiced in its ability to prepare for the hearing both by the procedural structure adopted by the Board, and by the Agency's refusal to produce the information and data that are so clearly relevant and necessary both to evaluate and critique the Agency's proposal, and to develop any alternative methodologies. As such, any decision by the Board will be tainted by the improper process that has put the intervenors in this position on the eve of the hearing.

Now that the intervenors have prepared to move forward under these difficult circumstances, the DHA requests that the Board stop this entire statutorily-required proceeding because the Agency does not have 100% of the data it needs to calculate the full AMCS. Anthem BCBS's opposition to DHA's motion to continue and its response to the recommended decision from the Hearing Officer explained the clarity of the statute, the significant prejudice that would result from adopting the DHA's schedule, and the lack of any significant reason to halt these proceedings. Anthem BCBS incorporates those filings here by reference.

II. THE MERITS: ANTHEM BCBS'S PRELIMINARY REVIEW OF THE MERCER REPORT REFLECTS THAT THE PROPOSED METHODOLOGIES WILL OVERSTATE COST SAVINGS

Anthem BCBS received the identification of DHA's proposed methodologies less than 48 hours before filing its prefiled testimony and, accordingly, has had only very limited time to review the proposals. DHA has provided none of the data that support its methodologies. While the details are as yet unknown, based on Anthem BCBS's preliminary review, the Agency's proposed methodologies will overstate cost savings.

A. The AMCS Calculation Should Be Limited To Increased Enrollment In Mainecare Due To Eligibility Expansion And Other Cost Savings As A Result Of The Operation Of Dirigo Health

The Dirigo Legislation limits the Board in what it may consider in the calculation of AMCS. Specifically, the Board must determine

> the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A).

There are thus only two types of savings that the DHA Board may include in the calculation of AMCS: (1) increased MaineCare enrollment due to eligibility expansion, and (2)

cost savings, including reductions in bad debt and charity care, that are "as a result of the operation of Dirigo Health." While the Agency seems to acknowledge the latter core requirement in Mercer's "guiding principles" (s*ee, e.g.*, Prefiled Testimony of Steven Schramm, lns. 92-93: "the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system"), the methodologies put forth by DHA do not adhere to this principle.

B. DHA's Proposed Methodologies For Calculation Of AMCS Are Not Limited As The Statute Directs.

Because the Agency has not provided the data and documentation supporting its proposed methodology, Anthem BCBS can only provide preliminary comments as to the Agency's methodology described in the Mercer Report that was made available on March 20th. Given that the Mercer Report was made available only a few days ago, Anthem BCBS and its experts have not had the opportunity to thoroughly review it as of the time that this Brief was due and will likely provide additional analysis through the testimony of its witnesses at the hearing. However, at this point, a number of apparent flaws in the Board's proposed methodology for the second assessment year have been preliminarily identified.

1. General Flaws in DHA's Proposed Methdologies.

Flaws unique to each of the proposed measures are discussed below, but other flaws are repeated in each of the proposed measures. First, the proposed measures ignore the statutory requirement and "guiding principle" that the AMCS must be as a result of the operation of Dirigo Health. Indeed, consistent with its proposal for the first assessment year, it appears that DHA proposes a methodology for calculating AMCS that requires no analysis or effort to determine what factor(s) caused the calculated "savings". Instead, 100% of the calculated "savings" are simply deemed to be as a result of the operation of Dirigo Health.

The second flaw that permeates all of the proposed measures is the failure to maintain any link between the calculated AMCS and the actual amount of cost savings realized by the private payers who will pay the savings offset payment ("SOP").

Mercer concedes in its report and prefiled testimony that savings should be limited to those that reduce cost shifting to private payers, or otherwise lower the costs for the private payers who pay the SOP. *See, e.g.*, Schramm Prefiled, lns. 98-99 ("When calculated, the savings will be used to sustain DirigoChoice at no additional costs"); 186-187 (advocating that reductions in CON spending should be included in AMCS because the resulting "need for payer rate increases is reduced"); 198-202 ("savings will accrue to private payers as the need for cost increases from other payers will be reduced as additional cash is received by hospitals and physicians. There will be reductions in cost-shifting due to increased funding for hospitals, and a reduction in cost-shifting due to increased funding for physicians.").

Anthem BCBS's has no difficulty with this concept; indeed, Anthem BCBS has long advocated that the AMCS calculation must provide the symmetry envisioned by the Dirigo Legislation and establish as savings only those costs savings that have inured to the benefit of the private payers who will pay the SOP. Anthem BCBS's difficulty is that the methodologies proposed by DHA are not designed to measure that symmetry. They instead would count any events that "should" reduce hospital costs and "should" thereafter reduce hospital charges. By presuming away this necessary link, DHA's proposed measures do not anticipate engaging in any follow-up with the hospitals that allegedly experienced the "savings" to determine (1) whether the calculated savings were actually realized by the hospital, and if so, (2) whether the reductions in the hospital's costs translated into a corresponding reduction in the charges paid by

the private payers, and if so, (3) whether those reduced charges were as a result of the operation of Dirigo Health.

Anthem BCBS fully agrees that hospital cost savings that result in a reduction in charges to private payers lead to reduced premium rates and, accordingly, are appropriately included in the calculation of AMCS. If that symmetrical approach were adopted by the DHA, Anthem BCBS would support it, as reflected in Anthem BCBS's proposed methodology, described in the prefiled testimonies of Sharon Roberts and Jack Keane, and outlined below. The DHA methodology, instead, attempts to measure hospital cost savings; assumes that all of those "savings" result in corresponding reductions in the charges paid by private insurers; ignores that the majority of hospital spend in Maine is from governmental, not private payers; and then attributes all of those "savings" to the operation of Dirigo Health.

Finally, all of the savings methodologies proposed by DHA fail to account for the fact that upwards of 50% of hospital revenues are derived from governmental, not private, payers. It perhaps goes without saying that it is both inequitable and inappropriate to require the already-burdened private payers to pay an SOP that is based on savings that have benefited governmental payers. In the absence of a provision that assesses governmental payers their proportionate share of the SOP, that percentage must be determined and removed from the calculation of the AMCS that is used to calculate the private payers' SOP.

2. Specific Flaws: The Composite CMAD Methodology Proposed By DHA, While Potentially An Improvement Over The Methodology DHA Proposed Last Year, Remains Flawed.

The "composite" CMAD methodology proposed by DHA, assuming we understand it correctly and also assuming the methodology is a permissible means of calculating AMCS under the Dirigo Legislation, is potentially an improvement over the methodology proposed by DHA in the first year assessment, but in addition to the general flaws articulated above, remains flawed

because it (1) fails to acknowledge the reality that not all hospital cost reductions result in reductions in charges, (2) counts as "savings" results that may reflect expected cost growth that is line with pre-Dirigo experience, and (3) is subject to manipulation.

As the testimonies of Jack Keane and Tom Drottar explain, it is irrefutable that insurance carriers pay for the health care of their insureds based on hospital charges. Reductions in those hospital charges are the only way that those reductions may be included in the premium rates that are paid by those with private insurance. Reductions in hospital costs may, for a whole host of reasons, not lead to reductions in hospital charges. Accordingly, DHA's continued reliance on a cost-based methodology remains flawed.

Although Anthem BCBS must necessarily reserve judgment until DHA produces the absent calculations and data, the composite CMAD methodology appears to be an improvement over last year's methodology, which ignored results "above the line" and simply aggregated all results below the line. The proposed methodology remains flawed, however, because it still fails to account for the fact that hospital costs, even aggregated, are expected to fluctuate. Accordingly, picking a single value as representative of the expected growth in aggregate costs and deeming results below that value as "savings" means that expected results will be counted and thus the calculation of AMCS will be overstated.

Finally, the proposed composite CMAD methodology is flawed because it may be subject to manipulation of outpatient charges. The net result would be artificial savings counted in the Dirigo methodology with no associated real savings.

3. Specific Flaws: DHA's Proposed Uninsured Measures Overstate Cost Savings Because They Would Count Reductions In Hospital Revenues As Cost Savings When They Are, In Fact, The Opposite.

Although DHA has not yet produced any calculation or data, its methodology for counting the impacts of those formerly uninsured who obtain insurance coverage assume,

without apparent support, that increases in enrollment in Dirigo emanate from the uninsured ranks and therefore should be counted in the calculation of AMCS. This assumption fails to acknowledge that the numbers of uninsureds in Maine has remained relatively stable, while those enrolled in commercial insurance products have reduced. If instead of uninsureds the increase in enrollment in DirigoChoice has, in part, been those formerly insured by commercial carriers, hospitals would not experience an increase in revenue from that increased enrollment. The Dirigo Health Agency has information from its application process enabling it to identify the members enrolling who were previously insured and this should be reflected in their methodology. The methodology also appears to make the unsupported assumption that there is no bad debt and charity care costs associated with DirigoChoice members.

In its summary description of the calculation of Mainecare expansion, it appears that the Mercer methodology also does not account for previously insured customers moving to MaineCare. When that happens, the hospital experiences a decline in revenues because MaineCare reimbursement rates are less than the rates paid by private insurers. Accordingly, the Mercer methodology produces "savings" in situations where hospital revenues actually go down. Obviously, hospitals cannot pass on as "savings" a reduction in their revenues.

The woodwork effect measure is unclear and unsubstantiated by data. The Superintendent found that DHA failed to provide any factual support for its first year woodwork calculation and there is no reason to believe the Superintendent will find otherwise for the second assessment year.

4. Specific Flaws: The CON/CIF Is Speculative And Duplicative.

DHA proposes to aggregate CON/CIF projects to create a purported historical average and, from that, attempt to discern whether actual CON/CIF activity in the measuring period

demonstrates "savings." This methodology ignores the reality that each CON/CIF project is unique and the determination of why a particular project was or was not completed can only be made by performing a project-by-project analysis. There are many reasons, entirely unrelated to the operation of Dirigo Health, that a hospital or other non-hospital provider may make the decision to forego completion of a new project. Moreover, not all new projects increase costs. Many hospital projects create savings to the hospital through greater efficiency or by driving down prices through competition. Lumping all projects together and attempting to create an artificial average dollar amount of hospital spending on new projects and deeming anything less than that to be "savings" ignores these realities and is therefore an inappropriate measure of real cost savings.

Even if this were a reasonable measure of expected versus actual CON results (which it is not), the CON measure is duplicative of the proposed CMAD methodology. All costs are included in the CMAD methodology, including those hospital costs associated with CON projects. As such, any increase or decrease in CON-related costs is already reflected in the CMAD calculation. Including those changes in a CON measure as "savings" would be double counting.

5. Specific Flaws: Time Value Of Money On PIP Settlements.

The DHA proposed methodology appears to track the Superintendent's determination in the first assessment year that the only amount that could be included in the AMCS is early payment of PIP settlements. Anthem BCBS remains troubled that a delay in payment to hospitals of PIP amounts that results in a lawsuit and settlement, none of which is related in the least to the operation of Dirigo Health, could be counted in the calculation of AMCS.

The result of all of these flaws is that the DHA methodologies overstate, and in some cases do not even measure, the cost savings that are as a result of the operation of Dirigo Health.

III. THE BOARD'S ADOPTION OF ANTHEM BCBS'S PROPOSED METHODOLOGY WOULD RESULT IN A MORE ACCURATE CALCULATION OF AMCS.

The issue of whether any CMAD methodology is authorized by the Dirigo Health Act at all is currently pending in Superior Court. The additional element in this year's assessment, as the Chamber has pointed out, is that there is no voluntary cost growth limit in the Dirigo Legislation for the measuring period for this year's assessment. Reserving all arguments on these issues, Anthem BCBS has developed a proposed alternative methodology that starts with the methodologies embodied in the Superintendent's Decision and Order from the first assessment year and offers what it believes are improvements on those methodologies. Specifically, Anthem BCBS's proposes an alternative methodology that (1) removes from the calculation of AMCS results that are expected, (2) provides a mechanism for verification that calculated savings are truly as a result of the operation of Dirigo Health and not other factors, (3) reduces the ability to manipulate results, (4) bases savings on charges, rather than hospital costs that may or may not lead to savings to private payers, (5) avoids overlapping savings measures that tend to result in duplicative savings, and (6) would impose on private payers only those savings that have accrued to private payers by explicitly accounting for those savings that have accrued to governmental payers.

A. Naturally Occurring Fluctuations In Hospital Expenses (Or Charges) Are Established Using A Corridor Approach And Expected Results Are Thereafter Removed From The Calculation Of AMCS.

As acknowledged by the Superintendent last year, one of the central flaws in the Board's CMAD methodology for the first assessment year was that the calculation failed to recognize and

take account of the fluctuations in hospital expenses that occur naturally from year to year, and have nothing to do with the operation of Dirigo Health.

> Given that operating expenses per CMAD for any hospital fluctuate from year to year for a wide variety of reasons, it is unreasonable to assume that any decrease over the base period is due to voluntary cost control while ignoring increases over the base period

First Assessment Year Decision and Order, Docket No. INS-05-700, p. 11. As the Superintendent recognized, expenses are *expected* to "fluctuate from year to year for a wide variety of reasons."

To correct the "straight line expectation" flaw, Anthem BCBS established in its proposed alternative a baseline corridor of expected expenses by comparing the annual increases or decreases in expenses per CMAD for each hospital compared to the change in HMBI for each of the years for which data is available prior to Dirigo. The difference between the HMBI and the change in the expense per CMAD would be recorded for each hospital for each pre-Dirigo year to establish the historical corridor of cost fluctuations during the pre-Dirigo period. The corridor is the band or range of experience within which hospital expense per CMAD increases and decreases fell during the pre-Dirigo period. This corridor thus establishes the expected range of costs for each hospital unrelated to the operation of Dirigo Health.[2]

Hospitals that experienced actual expenses within the expected corridor should be excluded from the calculation of AMCS because their expense growth kept pace with historical, pre-Dirigo expectations. Hospitals with actual expenses that were higher than the expected

[2] For example, assume the pattern for a particular hospital shows that its actual increase in Expense per CMAD was 1.5 percentage points above the HMBI for 2001/2000; .5 percentage points below the HMBI for 2002/2001; and 1.0 percentage points below the HMBI for 2003/2002. The corridor for this hospital would be the HMBI plus 1.5 and minus 1.0 percentage points. Thus, if the change in the Expense per CMAD for this particular hospital in the year to be used as the basis for an upcoming calculation of AMCS were 1.5 percentage points below the HMBI for that period, then it might be reasonable to consider this .5 percentage point difference between the actual change and the "low" side of the corridor as the starting point for identifying the savings that occurred in that year as a result of the operation of Dirigo Health.

corridor were excluded as well. However, hospitals with expenses that were lower than the expected corridor would be put into a group for further analysis.[3]

Once the subset of hospitals requiring further analysis is determined (i.e. those with expenses below the expected expense corridor), Anthem BCBS proposes follow-up with those hospitals to (1) confirm whether the analysis of their expenses was accurate, (2) if so, determine what factors caused the lower than expected expenses, and (3) whether those lower than expected expenses are embedded in the hospital's contract with carriers, like Anthem BCBS.

This alternative more accurately accounts for the fact that hospital expenses fluctuate naturally and, by performing analysis of those hospitals identified as experiencing cost growth that is truly lower than expected, the methodology ensures that expense reductions that are entirely unrelated to the operation of Dirigo Health are not included in the cost savings calculation.

B. Avoidance of Possible Manipulation of CMAD To Inflate Cost Savings

Because CMADs form the denominator for the expense per CMAD approach, anything that increases that denominator will have the effect of reducing the expense per CMAD and any associated trend in expense per CMAD over time. As Anthem BCBS's expert will testify, the outpatient component of the CMAD calculation is subject to manipulation because it is based in part on hospital *charges* per outpatient visit. The higher the outpatient charges, the higher the expense per CMAD denominator will be. Because hospitals have substantial freedom to raise their outpatient charges, increases in those charges do not necessarily reflect increases in the

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[3] Using this approach and available data from last year's SOP proceeding, Anthem BCBS' expert witness Jack Keane calculated a potential savings across all payors (governmental and private) of $10.8 million that could potentially be attributed to the operation of Dirigo Health, subject to the further analysis required under step 2 of Anthem BCBS's proposed methodology, and subject to reduction to account for the fact that private payors in Maine cover only about 40-50% of all patients. Therefore, subject to further hospital-specific investigation, only 40-50% of that $10.8 million in savings should be available for inclusion in the SOP.

level of outpatient services that were provided. Accordingly, by raising their outpatient charges, hospitals can artificially increase the denominator of the expense per CMAD amount and lower their expense per CMAD. In this way, a hospital can appear to be generating cost savings that are not real.

This potential weakness is very important because it could create double counting. Private insurers pay for almost all hospital outpatient services at a percentage of billed charges. In the scenario described above, a hospital could raise its outpatient charges, with the effect of increasing its number of CMADs and lowering its measured increase in expense per CMAD, while the private insurers would have to pay higher costs in terms of higher charge-based payments. The AMCS would be inflated and, as a result, private insurers would be assessed an inflated SOP while, at the same time, the *higher* charges would already have been reflected in health care payments and premiums.

To thwart the possibility of manipulation, Anthem BCBS proposes that the ratio of outpatient charges per visit to inpatient charges per discharge be frozen at the latest pre-Dirigo level until a better measure of the quantity and complexity of outpatient services can be developed. A better measure can eventually be developed through usage of the "ambulatory payment categories" (APCs) and fee schedules to pay for outpatient services utilized by Medicare.

As explained in Mr. Keane's testimony, moving to a charge-based methodology would remove the ability to manipulate data to achieve results.

C. The Methodology For Calculating Savings Should Be Based On Hospital Charges, Not Costs.

Anthem BCBS has explained in testimony and above the reason that reductions in charges is the only means by which private payers realize actual, rather than hypothetical,

savings. As such, Anthem BCBS proposes the corridor analysis described above, but with the focus on charges, rather than costs. This methodology has the added benefit of capturing all potential savings, including reductions in bad debt and charity care costs that reduce charges to private payers.

D. Account for Savings Passing Through To Governmental Payers

The flaws in DHA's proposed methodologies are compounded by the fact that the Board counts its savings across all payers, despite the fact that Medicare and Medicaid account for more than half of all hospital utilization in Maine and the state has no mechanism for collecting the related portion of the SOP from the federal government.[4] Clearly any AMCS must be apportioned to eliminate any unrecovered savings that flow through to governmental payors.

CONCLUSION

The procedures adopted by the Board, and the manner in which the Board's Agency has failed to comply even with those procedures, have substantially prejudiced Anthem BCBS and prevented the Company and other intervenors from participating meaningfully in this proceeding.

The methodology presented in the Mercer Report will not yield an accurate measure of AMCS for the reasons discussed herein. To correct the flaws in the Agency's methodology, Anthem BCBS recommends that the Board adopt the alternative methodology outlined in this brief and presented in more detail by Anthem BCBS's expert, Jack Keane.

[4] The same phenomenon holds true with calculating savings for physicians. Any savings attributed to physicians from the operation of Dirigo Health must be apportioned to account for the fact that some of the savings will inure to the benefit of government payors.

Dated: March 24, 2006

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Certificate of Service

I, Christopher T. Roach, Esq. certify that the foregoing Anthem Health Plans of Maine, Inc.'s Prehearing Brief was served this day upon the following parties via U.S. and Electronic Mail.

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Dated: March 24, 2006

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